

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last GLADYS BEATRICE BOWEN						2a. DATE OF DEATH Month Day Year 12 31 68		2b. HOUR P 7:40 M		17313	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-4-2/ 1922		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Calvert County Md.					
10. CITY OR TOWN OF DEATH Prince Frederick Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County House Wife		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) at Home		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Prince Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER None			
14. FATHER'S NAME First Middle Last Frank Penn				15. MOTHER'S MAIDEN NAME First Middle Last Helen Redding							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 212-62-1326		17. INFORMANT Mr. Norman Swann-Son-Prince Fredrick, M.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 277X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Obesity & hypertension DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 331X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10/10 , 19 65 , to 12/31 , 19 68 , that (I) (we) last saw the deceased alive on 12/31 , 19 68 , and that in (my) (our) apian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George J. Weems		DEGREE GEORGE J. WEEMS M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/31/68					
22d. PHYSICIAN'S NAME (Type) GEORGE J. WEEMS M. D.		22e. ADDRESS HUNTINGTOWN, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/4/1969		23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery, Wayside, Maryland		23d. LOCATION (City or Town) (County) (State) MD.					
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		ADDRESS		25a. RECD BY REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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17303

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17314

1. DECEASED-NAME (Type or Print) <i>Lander Beatrice Brown</i>		First Middle Last		2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> <i>12 10 68</i>		2b. HOUR <i>10</i> M.	
3. SEX <i>F</i>	4. RACE <i>C</i>	5. DATE OF BIRTH <i>June 23 1913</i>	6. AGE (In years) <i>55</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <i>12</i> Day <i>11</i> Year <i>68</i>	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Cabot</i> Md.	
10. CITY OR TOWN OF DEATH <i>Crown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>None</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Cabot</i>		13c. CITY OR TOWN <i>Crown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last <i>Marion Holland</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Nancy Marshall</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <i>577346766</i>		17. INFORMANT <i>Wm Brown</i>		ADDRESS <i>Dum, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Cardiovascular accident</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Found dead in bed</i>							
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____		21b. TIME OF INJURY Month, Day, Year <i>NOV 19</i> A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) _____		21f. LOCATION Street or R.F.D. No. _____		City or Town _____ County _____ State _____	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>H W Wald</i>		EXAMINER'S NAME (Type) _____		M.D. _____		22b. DATE SIGNED <i>12/11/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) _____		23b. DATE <i>12 -14-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Hope Ch. Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Sunderland Cal. Md</i>	
24. FUNERAL DIRECTOR <i>Penney E. Sewell</i>		ADDRESS <i>Prime Fred-Md</i>		25a. REC'D BY REGISTRAR <i>DEC 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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17304										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17315																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
John										Hammerbacher										12 4 68										1:20 M																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
Male										White										11-27-87										87 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Md.										U. S. A.																				Calvert										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Prince Frederick										Calvert County Hospital																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Md.										Calvert										Owings										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
Hammerbacher										Anna										Kratz																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
Yes										218 30 3914										Claude Owings										Owings, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) Cerebral vascular accident																																																											
4369										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																							
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																											
331X																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																																							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 27, 1968, to Dec. 4, 1968, that (I) (we) last saw the deceased alive on Dec. 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																																							
Page C. Jett, M. D.																																																											
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
										Prince Frederick, Maryland																																																	
23a. BURIAL, CREMATION, ETC. (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										12/7/68										Friendship Cemetery										Friendship Anne Arundel Md																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Hutchins Funeral Home										Owings, Md.										DEC 11 1968										Charles Judge																													

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FOR STATE
HEALTH/DEPT.

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Item 4 Film 08
1/6/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17316

1. DECEASED-NAME (Type or Print) <i>James</i>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <i>12</i> Day <i>27</i> Year <i>1968</i>			2b. HOUR <i>10</i>		
3. SEX <i>M</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>7/7/04</i>	6. AGE (in years last birthday) <i>64</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>12</i> Day <i>27</i> Year <i>1968</i>		
7a. BIRTHPLACE (State or foreign country) <i>W.D.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Cecil</i>			10. CITY OR TOWN OF DEATH <i>Smithland</i>		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Calhoun</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>Cecil</i>			13c. CITY OR TOWN <i>Smithland</i>		
14. FATHER'S NAME First <i>Louis</i> Middle <i>H</i> Last <i>Jones</i>			15. MOTHER'S MAIDEN NAME First <i>Madara</i> Middle <i>Jones</i> Last <i>Jones</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, if not, state when) <i>No</i>		
16b. SOCIAL SECURITY NO. <i>219 018136</i>			17. INFORMANT <i>Mrs. J. Jones</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured femur West down</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Gunshot Fracture</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>352X</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Had been confined to bed 7 yrs</i>								
19a. DATE OF OPERATION <i>1961</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. <i>0</i> P.M. <i>0</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>H W Ward</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>12/27/68</i>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>1-1-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Edmonds Church</i>		
			23d. LOCATION (City or Town) (County) (State) <i>Chesapeake Cal. Md.</i>			24. FUNERAL DIRECTOR <i>Leroy E. Berry</i>		
			ADDRESS <i>Huntingtown, Md.</i>			25a. REC'D BY REGISTRAR <i>DEC 30 1968</i>		
			25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>					

The following is a list of the plants
 which have been found in the
 State of California, and which
 are now being cultivated in
 the State of California.
 The list is given in the
 following order: first, the
 plants which are now being
 cultivated in the State of
 California; second, the
 plants which are now being
 cultivated in the State of
 California; and third, the
 plants which are now being
 cultivated in the State of
 California.

FOR STATE HEALTH DEPT.

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17306

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17317

1. DECEASED-NAME (Type or Print) <i>Lorena Virginia Lockie</i>		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 12/1/68		2b. HOUR 4 M	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>12/25/08</i>	6. AGE (in years) <i>59</i> YRS	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS HOURS _____ MIN. _____
7a. BIRTHPLACE (State or foreign country) <i>Md</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>		
10. CITY OR TOWN OF DEATH <i>Solomons</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Cabot</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Resident before admission) STATE <i>Md</i>		13b. COUNTY <i>Cabot</i>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER _____	
14. FATHER'S NAME <i>Elbert E. Dixon</i>		15. MOTHER'S MAIDEN NAME <i>Naomi Overton</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>207-34-0534</i>		16c. INFORMANT ADDRESS <i>Lancis V. Shea</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Had been a pt of coronary</i>					
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) _____		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>12/1/68</i>	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>Cowling, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Dec. 4, 1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Solomons Methodist Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Solomons, Cabot, Md.</i>		
24. FUNERAL DIRECTOR <i>A. Q. Herkner & Son, Port Republic, Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 4 1968</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17307

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17318

1 DECEASED NAME (Type or Print) <i>Herpin Joseph Mundell</i>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 12/12/68 <i>10 P M</i>			2b HOJR M			
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>10/12/14</i>	6 AGE (In years last birthday) <i>34</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i> MIN. <i>0</i>	2c DATE PRONOUNCED DEAD Month <i>12</i> Day <i>12</i> Year <i>1968</i>			
7a BIRTHPLACE (State or foreign country) <i>DC</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md.			
10 CITY OR TOWN OF DEATH <i>Wheat Branch</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Calvert</i>		12a USUAL OCCUPATION (Kind of work done during most of working life) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>MD</i>		13b COUNTY <i>Calvert</i>		13c HOME CITY LIMITS? <i>NO</i>		13e STREET AND NUMBER <i>603 Third St</i>			
14 FATHER'S NAME <i>Harry K Mundell</i>			15 MOTHER'S MAIDEN NAME <i>Mary Cole</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or, if unknown, state year of discharge) <i>NO</i>		16b SOCIAL SECURITY NO <i>57830 6483</i>		17 INFORMANT <i>Mark J Mundell</i>		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>7824</i> (b) <i>12-14</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Was speaking at Ann Meeting & dropped over</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>A W Ward</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <i>12/12/68</i>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
<i>Burial</i>		<i>12/17/68</i>		<i>Arlington National</i>		<i>Ft. Myer Va</i>			
24 FUNERAL DIRECTOR <i>Hutchins</i>				ADDRESS <i>Funeral Home Owings, Md.</i>		25a RECD BY REG STRAR DATE <i>DEC 20 1968</i>		25b REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17308										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17319									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last Marie Elizabeth Plitt										Month Day, Year December 14, 1968										7:00 PM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			7. UNDER 1 YEAR			8. UNDER 1 YEAR			9. UNDER 24 HRS.											
Female			White			9-8-91			77 YRS.																				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED- <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			U.S.A.						Calvert County Md.																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY														
Prince Frederick					Calvert County Hospital					Housewife																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13d. STREET AND NUMBER														
Maryland					Calvert					Huntingtown					Neeld Estate														
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
John					Nies					Margaret																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
No					212-10-0556					Carl E. Plitt, Huntingtown, Maryland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral accident</u>																													
4369 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																													
DUE TO, OR AS A CONSEQUENCE OF																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-19-68</u> , 19 <u>68</u> , to <u>12-14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>George J. Weems</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 12-14-68														
22d. PHYSICIAN'S NAME (Type) George J. Weems, M.D.										22e. ADDRESS Huntingtown, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					12-17-68					Parklawn Cemetery					Rockville, Maryland														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
ROBERT A. PUMPHREY, Bethesda, Maryland										DEC 19 1968										<u>Charles Judge</u>									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15AE 5-64
10M REV 1-65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			2b. HOUR
Sadie Powell						Month Day Year 12 5 1968			6:30 AM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD			2d HOUR
female	white	2-11-90	78 YRS			Month Day Year 12 5 1968			6:30 AM
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.
Delaware		U.S.A.				Calvert			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Prince Frederick		Calvert County Hosp.		Housewife		Home			
13a U.S.A. RESIDENCE (Where deceased lived if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER
Maryland			Queen Anne		Sudlersville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Henry Williams						Catherine Marvell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
			215-50-4479		Helen P. Marsellas Owings, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>fractured hip</i>									2 1/2 mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <i>age</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<i>fell off curb and fractured hip (left)</i>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			
9/15/68 - 10/31/68			fractured hip			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2, Item 18.)				
			8 - 9/16 1968		fell while walking				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
		Home		Sudlersville		Queen Anne		Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			12/5/68
Hugh W. Ward, M.D.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Dec. 7, 1968		Sudlersville Cemetery.		Sudlersville, Q.A.			Md.
24 FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Edward Fellows & Son, Millington, Md. 21651					DATE DEC 9 1968		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17310										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17321									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Louis Ray Snider										Dec. Month 13 Day 1968										M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Male			White			4/17/1893			75 YRS.			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Michigan			USA						Calvert						Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Prince Frederick					Calvert House Nursing					Machinist					Navy Yard														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Md					Calvert					North Beach																			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
Charles Snider					Ida D. Norris																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
No																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collaps</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1992</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>12-13</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Charles Judge</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					12/18/68					Cedar Hill					Suitland, Md														
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Hutchins Funeral Home										Owings, Md										DEC 20 1968					<u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Elbert Thomas Wells						2a. DATE OF DEATH Month Dec Day 12 Year 1968			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 2, 1881		6. AGE (In years last birthday) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		7. IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Calvert Md.					
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert Co. Nursing Hl		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY AA		13c. CITY OR TOWN Friendship		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First William Middle T. Last Wells				15. MOTHER'S MAIDEN NAME First Miranda Middle Last Ward							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212 36 7537		17. INFORMANT Address Mrs Mary L. King Chesapeake Beach.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca bladder 188X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1810											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10/1 , 19 48 , to 12/12 , 19 68 , that (I) (we) last saw the deceased alive on 12/12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) [Signature]				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/16/68		23c. NAME OF CEMETERY OR CREMATORY Friendship Ch. Cem		23d. LOCATION (City or Town) (County) (State) Friendship Md					
24. FUNERAL DIRECTOR Hutchins Funeral Home				ADDRESS Owings, Md		25a. REC'D BY REGISTRAR DEC 20 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

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